Review Body on Doctors' and Dentists' Remuneration

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Forty-Sixth Report 2018

Chair: Professor Sir Paul Curran

Cm 9670

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The Review Body on Doctors' and Dentists' Remuneration was appointed in July 1971. Its terms of reference were introduced in 1998, and amended in 2003 and 2007 and are reproduced below.

The Review Body on Doctors' and Dentists' Remuneration is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health and Social Care, the First Minister and the Cabinet Secretary for Health and Sport of the Scottish Parliament, the First Minister and the Cabinet Secretary for Health and Social Services in the Welsh Government and the First Minister, Deputy First Minister and Minister for Health of the Northern Ireland Executive on the remuneration of doctors and dentists taking any part in the National Health Service.

In reaching its recommendations, the Review Body is to have regard to the following considerations:

> the need to recruit, retain and motivate doctors and dentists;
>
> regional/local variations in labour markets and their effects on the recruitment and retention of doctors and dentists;
>
> the funds available to the Health Departments as set out in the Government's Departmental Expenditure Limits;
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> the Government's inflation target;
>
> the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

The Review Body may also be asked to consider other specific issues.

The Review Body is also required to take careful account of the economic and other evidence submitted by the Government, staff and professional representatives and others.

The Review Body should also take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief and disability.

Reports and recommendations should be submitted jointly to the Secretary of State for Health and Social Care, the First Minister and the Cabinet Secretary for Health and Sport of the Scottish Parliament, the First Minister and the Cabinet Secretary for Health and Social Services of the Welsh Government, the First Minister, Deputy First Minister and Minister for Health of the Northern Ireland Executive and the Prime Minister.

The members of the Review Body are:

> Professor Sir Paul Curran *(Chair)*
> David Bingham
> Mehrunnisa Lalani
> Professor Kevin Lee
> Professor James Malcomson
> John Matheson, CBE
> Nigel Turner, OBE
> Jane Williams

The Secretariat is provided by the Office of Manpower Economics.

Executive Summary

The DDRB's remit group

1. Across the United Kingdom (UK) the National Health Service (NHS) spends around £120 billion per annum and is the country's largest employer, with around 1.4 million staff. Our terms of reference cover over 215,000 doctors and dentists providing NHS services. These include 70,000 hospital doctors, 65,000 doctors and dentists in training, around 50,000 General Medical Practitioners (GMPs), and around 30,000 General Dental Practitioners (GDPs).

2. The remit group is complex: some of its members are salaried employees of the NHS, such as those who work in hospitals. Others, such as GMPs or GDPs, may work in the primary care sector as independent contractors, as salaried employees of practices, or locums.

Context

3. The position of the wider economy remains an important backdrop to our work (see Chapter 2).

    - The economy grew by 1.8 per cent in 2017, following growth of 1.9 per cent in 2016. The prospects for economic growth appear relatively muted across the UK, both over the next year and coming few years.
    - Inflation peaked towards the end of 2017. CPI inflation was broadly stable at around 3 per cent over the second half of 2017 and fell sharply to 2½ per cent in the early part of 2018. Over the period of the settlement it is generally expected to be close to 2 per cent and to fall towards the 2 per cent target by 2019.
    - Growth in average earnings had picked up through 2017, and at the time of making our recommendations was just over 2½ per cent. Pay settlements in the wider economy have also started to increase.

4. Over the course of previous reports, we have noted other background trends which continue to concern us. These include:

    - The level of motivation across our remit group, and their expectations about pay, as the country emerges from a period of tight public sector pay restraint into an era of more flexibility;
    - The challenges of addressing the flexibility and work-life balance sought by some in the modern medical workforce;
    - The negative impact on retention of changes to the taxation of pension benefits;
    - Recent restrictions in the availability of visas for overseas doctors and dentists seeking to work in the UK, which increase the challenge of recruitment and retention;
    - Uncertainties about the impact of Brexit.

5. We noted that, whilst we were engaged in our work, all four countries in the UK published strategy documents relating to their respective health sectors:

    - In England, a draft workforce strategy for the NHS in England went out to consultation in December 2017, with the final strategy to be published in July 2018.
    - In Wales, a review of health and social care in the country was published in January 2018. One of the goals was *enriching the wellbeing, capability and engagement, of the health and social care workforce.*
    - In Scotland, the Government published its National Health and Social Care Workforce plan in three parts between June 2017 and May 2018.
    - In Northern Ireland, the Department of Health published in May 2108 its own Workforce Strategy, building on the work of the Bengoa report.

6. There were further significant developments. In March 2018, the NHS Staff Council reached a framework agreement on the proposed reform of the NHS pay structure for Agenda for Change (AfC) staff. In June 2018 the majority of NHS Trades Unions announced that they had accepted the proposed pay deal for England. In Scotland on 9 June 2018 the First Minister announced that AfC staff in the NHS earning up to £80,000 would receive at least a 3 per cent pay uplift and those earning £80,000 and over would receive a flat rate increase of £1,600. The delivery of medical care is a collaborative effort between those in our remit group and staff in the AfC grades.

7. The past year has also seen:

    - Agreement between the NHS Employers and the BMA on reform to the current system of local Clinical Excellence Awards (CEAs).
    - The roll-out of the new junior doctors' contract in England.
    - In Scotland, from April 2018 the introduction, with BMA agreement, of a new contract for the provision of General Medical Services.

Our remits and our process

8. We received remits this year from each of the four countries of the UK.

9. The Chief Secretary to the Treasury (CST) wrote to us to say that the last Spending Review budgeted for 1 per cent average basic pay awards, but that the Government recognised that in some parts of the public sector, particularly in areas of skill shortage, more flexibility may be required.

10. In Scotland, the new public sector pay policy explicitly set out a guaranteed minimum increase of 3 per cent for those earning £36,500 or less, up to 2 per cent for those earning below £80,000 and a maximum increase of £1,600 for those earning £80,000 or more.

11. In the same letter referred to in paragraph 9 the CST went on to say that the move to a single fiscal event in the autumn of 2017 would mean that the round would run to a later timetable this year. We asked the evidence-providers to make written submissions by 18 December 2017. However, written evidence from the Department of Health and Social Care (DHSC) was not received until 19 January 2018 and evidence from the Scottish and Welsh Governments was not received until 7 February 2018 and 19 February 2018 respectively. The BMA and BDA, both raised concerns about the late delivery of written evidence by other parties.

12. We received written and oral evidence from the Department of Health and Social Care (England); the Welsh Government; the Scottish Government; the Department of Health (Northern Ireland); NHS England; NHS Improvement; Health Education England; NHS Employers; NHS Providers; the British Medical Association (BMA); the British Dental Association (BDA); and the Hospital Consultants and Specialists Association (HCSA).

The case for a pay award

13. We understand that pressure on health services remains severe, given the current financial settlement. Over recent years we have felt that the evidence supported pay increases for our remit group that have been in line with the government's pay policy, but we noted last year that the case for continued pay restraint was diminishing. We have not seen sufficient evidence to persuade us of the case for a settlement that would undo the effects of this period of pay restraint, but we have heard evidence that employers are facing increasing difficulties recruiting and retaining the medical and dental workforce they need, and that the motivation and morale of doctors and dentists and their satisfaction with their pay have declined.

14. On recruitment, this year we have seen a continuing decline in the numbers of university applications for pre-clinical medicine and, pre-clinical dentistry, but we have been presented with no evidence that quality problems are starting to emerge.

15. We have heard that overseas recruitment may be affected by uncertainty around Brexit, by the ability of candidates to obtain visas to enter the UK, and by the time taken to procure such visas. Moreover, the relative fall in the value of the pound since the middle of 2016, particularly against the Euro, will have reduced for overseas applicants the financial value of medical posts paid in sterling.

16. An increasing proportion of junior doctors are stepping out of training after Foundation Year 2. This phenomenon may be a reflection of the choices doctors and dentists are now making early in their career about work-life balance. We referred to this in our 45th Report 2017, and employers in the NHS may have to accommodate such demands. However, the data we have seen suggests that the vast majority are returning within a year or two and are not being permanently lost to the NHS.

17. We have seen an increase in the number of doctors choosing to retire at an earlier age. One cause may be the impact of lowering the thresholds of the pensions annual and lifetime allowances.

18. On motivation and morale, Staff Survey data for 2017 in England were generally less positive than in 2016. The results showed a decrease in engagement scores, a fall in satisfaction with pay, and a fall in job satisfaction in general. Meanwhile, workforce pressures remained high and showed little sign of easing.

19. We considered the extent to which it was appropriate to target some or all of our recommendations on specific areas. We had to balance this against the possible demotivating and divisive effect on those who would have lost out with an approach based solely on targeting.

20. We are convinced by the evidence we have seen that we have reached a point at which, if we are properly to balance the different factors listed in our terms of reference, a pay recommendation, with a general uplift greater than the 1 per cent which the UK Government states has been funded, now becomes necessary. We believe the workforce represented by our remit group should not now be expected to see their pay decline significantly further in real terms.

21. Both price inflation (as measured by CPI) and average earnings growth are an important part of this year's context. At the time of reporting both are at or around 2½ per cent, although CPI over the period of the settlement is generally expected to be close to 2 per cent.

22. Taking account of all these circumstances, we conclude that the appropriate level for a general increase, should be 2 per cent, which broadly maintains pay in real-terms. In making our recommendations we follow the practice we adopted in 2016 of expressing our pay recommendations for GMPs and GDPs net of expenses.

We recommend:

- **A minimum 2 per cent increase to the national salary scales for salaried doctors and dentists across the UK;**
- **For independent contractor GMPs and GDPs across the UK a minimum increase in pay, net of expenses, of 2 per cent;**
- **The maximum and minimum of the salary range for salaried GMPs be increased by 2 per cent;**
- **An increase in the GMPs trainers' grant and rate for GMP appraisers of 2 per cent;**
- **That the flexible pay premia included in the junior doctors' contract in England increase by 2 per cent.**

Targeting

23. As invited to do so by some of our evidence providers, we considered the case for targeting in some specific areas. We have focused on areas where the needs seem greatest. That has led us to focus our recommendations on GMPs and specialty doctors and associate specialists (SAS) this year.

General Medical Practitioners (GMPs)

24. Health providers are looking to increase the emphasis on primary care and to do so, increase the number of GMPs. This will require a combination of increasing the number of training places, overseas recruitment, and encouraging suitably qualified doctors to remain in, or return to, the workforce. Expanding the number of trainees will take a considerable number of years to have an impact, but overseas recruitment could have an impact more quickly. The ambition to expand the GMP workforces may be affected by uncertainty around Brexit and by the recent limited ability of candidates to obtain visas to enter the UK.

25. We observed that for GMPs in particular there were several specific issues potentially impacting on retention. These include:

- The extent to which the role of the GMP will change and the demands increase as a result of the greater integration of healthcare with social care;
- The increasing regulatory and administrative burden of running practices;
- The increasing demands posed by a rising and an ageing population with more complex needs;
- A decreasing willingness on the part of younger GMPs to work the number of sessions their predecessors worked;
- The data show an increase in the number of GMPs taking voluntary early retirement which may be linked to lowering the thresholds of the pensions annual and lifetime allowances;
- The increasing tendency for GMPs to prefer salaried employment to practice ownership;
- The fact that average gross earnings for GMPs, both contracted and salaried, were lower in nominal terms in 2015-16 than in 2006-07.

26. These concerns were underlined by results from the University of Manchester National GP Work Life Survey, published in May 2018. The survey reported an increase in the number of GMPs in England saying they were likely to leave direct patient care in the next five years, and the vast majority reporting considerable or high pressure from increasing workloads. Those conducting the survey found that low satisfaction and high pressure reported by GMPs in 2015 had been repeated in 2017, and said that this may have implications for recruitment, retention and patient care.

27. These factors all appear to have combined to make it less attractive to pursue the traditional GMP career path, which leads ultimately to practice ownership. This concerns us, particularly given the renewed emphasis being placed on the role of the GP in addressing demand for health services and hence delivering the productivity improvements sought from this. We believe that a pay response can help achieve this goal. We recognise that many of the problems facing this part of our remit group are not necessarily resolved through pay alone. However, we believe that if sufficient number of GMPs are either to be recruited from overseas or encouraged to remain in the service longer than they otherwise would have done, a pay response is required now. Such a response needs to be significant and go beyond our recommended base increase for the pay remit group as a whole.

- **We recommend for independent contractor GMPs an additional increase in pay, net of expenses, of 2 per cent above our minimum pay recommendation[1];**
- **We make a similar additional 2 per cent recommendation to the maximum and minimum of the salary range for salaried GMPs and to the GMP trainers' grant and the rate for GMP appraisers.**

Specialty doctors and associate specialists (SAS)

28. SAS doctors are the specialty doctors and associate specialists in the hospital system, of whom there are about 11,000 working across the UK, or around 1 in 10 of the hospital doctor workforce. In England, compared with other groups within our remit, SAS doctors contained the highest proportion of BAME staff, with only about 4 in 10 staff identifying as white. SAS grades also contained a higher proportion of women, at 45 per cent, when compared to consultants, where the figure was 35 per cent. Health Education England (HEE) data suggested that three-quarters of SAS doctors in England had obtained their primary medical qualification abroad.

29. We have drawn attention over several years to the pivotal role that SAS doctors play in the provision of hospital services. We were pleased to see this acknowledged by HEE who said that 'a genuine focus on recruiting, investing, supporting, rewarding and recognising SAS doctors can significantly help deliver medical rotas'.

30. We believe that SAS doctors are a significant element of the wider medical team that, through their front-line roles, make an important contribution to productivity. We would further observe that the role of an SAS doctor, if properly structured and managed in career terms, could be attractive to those whose commitments might otherwise deter them from following the path to consultant.

31. Results from the NHS Employers and BMA surveys highlighted problems with recruitment and retention to SAS posts, and pay, morale, workload, career progression and development were cited as factors. We noted that the 2017 Staff Survey results in England showed this group had the highest dissatisfaction with pay of the medical groups and felt least valued for their work.

32. Some steps have been taken to try to address these issues, such as through the introduction of the SAS Charters and the establishment of SAS doctors' development funds, but we were not encouraged to hear that a majority of the doctors concerned were unaware of the existence of a Charter and had not accessed the development funds.

33. The lack of any substantial progress in this area tends to reinforce the impression that the needs of this group are not being treated with what we feel should be the appropriate level of priority. A review covering the roles, career structure, salary structure and developmental support available to SAS doctors appears to us to be urgently needed. In the meantime, and in the interests of addressing the motivation of this group, and HEE's view that 'a genuine focus on recruiting, investing, supporting, rewarding and recognising SAS doctors can significantly help deliver medical rotas', we believe that a pay solution is required, and therefore,

    - **We recommend for SAS doctors an additional increase in pay, of 1.5 per cent, above our minimum pay recommendation.**

[1] In making our recommendation we follow the practice we adopted in 2016 of expressing our pay recommendations for GMPs net of expenses.

Doctors and dentists in training

34. In 2016 a new contract for doctors and dentists in training was introduced in England, with new trainees moving on to it from October of that year. The BMA said that the contract was being introduced without its agreement. Those working in Scotland, Wales and Northern Ireland are still on the previous contract.

35. Competition for places on pre-clinical medicine and pre-clinical dentistry courses remained strong, with roughly nine applications per acceptance in 2017. The number of applications for these courses has declined in recent years but we have seen no evidence to suggest this is leading to a reduction in quality.

36. Generally, between 2011 and 2016, for Foundation Years 1 and 2 (F1 and F2), the average total earnings for both doctors and dentists in training in England have remained significantly higher than median earnings of full-time employees but have nonetheless fallen back towards the median. However, we also observe that between September 2016 and September 2017, F1 and F2 monthly average total earnings for doctors in training in England has increased, following the introduction of the new contract, increasing by 5.4 per cent for F1, 2.4 per cent for F2, 4.3 per cent for core training, and 2.8 per cent for Registrars.

37. On this basis we do not believe that any further uplifts are required for doctors and dentists in training, beyond the minimum base increase which we have recommended above across the whole of our remit group.

38. The 2016 contract in England includes flexible pay premia for those undertaking general practice training, emergency medicine and psychiatry. HEE told us it had a key role in making recommendations on the targeting of flexible pay for hard to recruit specialties, and that it was now recommending the application of a premium for histopathology.

39. We heard some anecdotal evidence to suggest that the geographical distribution of both doctors and dentists may be influenced by where they finished their training.

40. As a matter of general principle, it seems right to us that any geographically-targeted pay premia should be designed so that they provide an incentive to doctors and dentists at the points in their careers where they will have the greatest impact. HEE said that the Targeted Enhanced Recruitment Scheme (TERS) for GMPs which targets this group early in their career, has been effective in encouraging trainees to take up posts in hard-to-fill areas. There are also a range of incentives in Scotland for doctors and dentists in remote and rural areas, and relocation packages for GMPs. We noted however that the Welsh government said in its evidence that it was opposed to targeting pay to specific staff groups. In general, TERS seem to us to be a potentially helpful way to address specialism and geographical shortages.

41. On implementation of either specialty or geographic premia, we observe that the DDRB was not asked to make a recommendation on specific proposals before it was decided to introduce the existing premia in England. We would support strongly the introduction of specialty premia in appropriate circumstances, particularly that proposed for histopathology. We would also support strongly the parties in their efforts to move forward the application of appropriately targeted geographic premia.

42. We would find it helpful in the evidence next year to receive reports on the impact of those premia already in place as the nature and the size of any such specialty or geographical premia should be kept under regular review to ensure that they do not outlive their usefulness. There may well be scope to expand existing premia further, but decisions on extension should be subject to the same careful review as decisions on continuation of the current schemes.

Consultants

43. In England the consultant workforce has doubled in size between 2000 and 2017. Some of this increase is the result of a conscious decision to change from a consultant-led service to a consultant-delivered service. We also observe that NHS output has grown, but at a slower rate than growth in consultant numbers.

44. Despite the long-term increase in consultant numbers, the evidence demonstrates that there continue to be persistent vacancies at consultant level. One issue that has been raised with us is the taxation of pensions. We have heard some evidence that lowering the thresholds of the pensions annual and lifetime allowances are leading to some more experienced members of the workforce choosing to retire earlier than they would otherwise have done. We observe that while anecdotal evidence is readily available, the numerical evidence in support of this assertion is not currently strong and more work needs to be done to better understand the situation.

45. Overall, we see no case at this stage for an uplift in the basic salary scales for consultants beyond our recommended minimum base increase of 2 per cent. Additional increases may become appropriate in the future if negotiations over a new contract for consultants deliver substantial productivity increases.

46. We are pleased to see that NHS Employers and the BMA have now been able to make progress towards implementing our 2012 recommendations in England, on the reform of local Clinical Excellence Awards (CEAs), though there is still further to go. We recognise the merits of the changes that have been agreed to local CEAs by NHS Employers and the BMA as part of the wider on-going consultant contract negotiations, including changes that make new awards non-pensionable, and the increased investment ratio. We recognise that these arrangements, which have only recently been negotiated, need to be given time to bed down in order to deliver the productivity outcomes which they are designed to support, before further changes are made to implement our 2012 recommendations more fully.

47. In recent years we have recommended increasing the value of consultant awards in line with our main pay recommendation for consultants and have done so again this year.

    - **We recommend that the value of Clinical Excellence Awards, Distinction Awards and Discretionary Points increase in line with our recommendation for the basic consultant pay scales.**

Dentists

48. Dentist numbers are steady, while figures showing access to and satisfaction with dental services are generally positive, although the BDA told us that increased pressures in the NHS and a reduction in dental incomes mean there is a looming crisis in general dental practice. Despite this, we were told in oral evidence from NHS England that they were able to let contracts for NHS dentistry and that some practices were being bought on the open market for good prices. However, the BDA challenged whether the prices paid represented the true earnings potential and that dental contracts were being handed back.

49. Although the headline income statistics show a reduction in dental incomes it is difficult to draw firm conclusions as the figures are based on headcount rather than full-time equivalents (FTE), so may reflect changes in working patterns rather than income.

50. We have heard that reform of dental contracts is an issue across the UK as a whole. We were told that new models of service provision had been piloted, some as far back as 2011, but we were given little evidence to help determine whether they were providing a suitable role model for the way(s) ahead. We expect to be kept informed of developments in this area and hope that at least in some parts of the UK the parties are able to reach agreement on the introduction of new arrangements.

51. On this occasion, as in previous years, we were struck by the relative absence of evidence or data to underpin any argument for recommendations going beyond the basic minimum increase we are recommending for the remit group in general. We will continue to monitor the situation, but we would ask the parties to consider what further data might be available. In the meantime, we have concluded that pay net of expenses should be increased by the same basic increase as for the rest of our remit group, namely 2 per cent.

Pay policy and affordability

52. All four countries in the UK have asked for recommendations, which we have made on the basis of the evidence we have received, and it is for each of them to decide how they respond. They will each face their own local challenges.

53. We regard the market for doctors and dentists as, for the most part, a UK-wide one. We have not seen any evidence to suggest that our remit group faces fundamentally different issues in different national markets, so our pay recommendations have not distinguished between the constituent countries within the UK.

54. We have noted in this respect the Welsh Government's view that considerations of fairness dictate that pay should align across the UK for the individuals fulfilling equivalent roles across the UK NHS and to avoid unhelpful internal competition for staff within the NHS workforce.

55. We have also noted that pay policy in Scotland, devised for the public sector as a whole, would relate to our remit group differentially. We have not sought to adjust our recommendations to take account of this. We have however noted that this different treatment may result in different outcomes for individual groups.

56. The Department of Health in Northern Ireland said that the 2016-17 pay policy as set by the previous Finance Minister continued to apply in 2017-18. In practical terms this may affect how quickly a response can be made to our recommendations. We recognise the political circumstances in Northern Ireland currently present challenges to moving ahead in the development of policy in this area, as in others.

57. Clearly, proposals for pay increases imply spending money which would not then be available for other health service priorities. However, the overall effectiveness of the NHS depends on recruiting, retaining and motivating adequate numbers of qualified staff, who can focus on caring for patients and on improving productivity. In that context, after nine years of pay awards no greater than 1 per cent, we are clear that increases of the order that we recommend this year are appropriate under the terms of our remit.

Looking ahead

58. The final part of our report looks forward to the pay round for the future year, and the areas on which we would expect to hear further about developments.

59. If the review body process is to work effectively, it is important that all the parties strive to work to an agreed timetable. Much of the Government evidence was delayed this year and both the BMA and the BDA were concerned that the process was delayed to such an extent this year that they gave evidence to DDRB after the date on which any award was due. For our 2019 Report we are seeking an early indication of when we can expect to receive evidence so that we can say when we would be able to submit our report.

60. Subject to this we set out in Chapter 11 the areas on which it would be helpful to have more evidence for the next round, which we have set out in tabular form.